

Patient's Name: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: : (____) _____

Sex: M / F Age: _____ Height: _____ Weight: _____ lbs. Neck Size: _____

	<u>Y</u>	<u>N</u>	<u>Comments</u>
Do you snore?	<input type="radio"/>	<input type="radio"/>	_____
Bed-partner's response:	<input type="radio"/>	<input type="radio"/>	_____
Do you stop breathing while you're asleep?	<input type="radio"/>	<input type="radio"/>	_____
Bed-partner's response:	<input type="radio"/>	<input type="radio"/>	_____
Are you sleepy during the day?	<input type="radio"/>	<input type="radio"/>	_____
Do you wake up with a headache?	<input type="radio"/>	<input type="radio"/>	_____
Do you Nap during the day?	<input type="radio"/>	<input type="radio"/>	_____
Any problems with sleepiness while driving?	<input type="radio"/>	<input type="radio"/>	_____
Do your legs move a lot when you sleep?	<input type="radio"/>	<input type="radio"/>	_____
Bed-partner's response:	<input type="radio"/>	<input type="radio"/>	_____
Do you act out while dreaming?	<input type="radio"/>	<input type="radio"/>	_____
Bed-partner's response:	<input type="radio"/>	<input type="radio"/>	_____
Do you wear oxygen when you sleep?	<input type="radio"/>	<input type="radio"/>	_____
If yes, at what setting? _____			

What time do you go to bed? _____ What time do you normally wake up? _____

Do you have any medical conditions? _____ If yes, please list them: _____

Do you take any medications? _____ If yes, please list them with the dosage: _____

Please return completed questionnaire
Northern Virginia Sleep Diagnostic Center
8503 Arlington Blvd., Suite 340, Fairfax, Va. 22031
Telephone #: 703-645-2244 / Fax #: 703-645-0711

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off* or *fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3: with 0 meaning you would never *doze* or *fall asleep* in a given situation; and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to *doze off* or *fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0=would never doze

2=moderate chance of dozing

1=slight chance of dozing

3=high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	CHANCE OF DOZING			
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (theatre/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with NO alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE: _____

NAME: _____

DATE: _____